



# St Bernadette's Primary School Lalor Park

## Notification and Request by Parent / Guardian for the Administration of Medication during school hours

I request that my child \_\_\_\_\_ be allowed to take medication at school  
*insert full name of student*

according to instructions from \_\_\_\_\_  
*full name of prescribing doctor*

Address of prescribing doctor (if applicable) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Contact Number: \_\_\_\_\_

The medication has been prescribed for the following reason:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Amount of medicine to be administered \_\_\_\_\_

What time is your child to take the medicine \_\_\_\_\_

How many days is the medicine to be administered \_\_\_\_\_

I hereby give permission to the Principal / Secretary to administer the above medication and if necessary to obtain relevant information from the prescribing doctor.

I accept and agree to observe the conditions imposed by the school and understand and agree that it is my responsibility to inform the Principal / Secretary of any changes involving administration of the medicine.

Signed .....  
(parent / guardian)

Date .....